FORM 25 M REV. 7/91

NORTH CAROLINA INDUSTRIAL COMMISSION - RALEIGH

PHYSICIAN'S ITEMIZED STATEMENT OF CHARGES FOR TREATMENT AND CERTIFICATION OF TREATMENT OF DISABILITY

The I.C. File No. is the unique identifier for this injury. It should be used on all future correspondence.
Code numbers assigned to each employer and carrier should be inserted before mailing.

I.C. File No. _____
Emp. Code No. _____
Carrier Code No. _____
Carrier File No. _____

1. DATE OF INJURY

2. EMPLOYEE:
ADDRESS:
CITY:

3. EMPLOYER:
ADDRESS:
CITY:

4. WHO RENDERED FIRST TREATMENT? _____ (NAME)

4A. WHO AUTHORIZED YOUR SERVICES? _____

5. CARRIER:
ADDRESS:
CITY:

6. DIAGNOSIS:

7. DATE	PS	PROC. CODE CPT 4TH ED.	DESCRIPTION OF SERVICE	DAYS/TIME	USUAL CHARGE
				TOTAL	

PLACE OF SERVICE (PS) CODES: 1. IP HOSP. 2. OP HOSP. 3. OFFICE 4. OTHER

8. OPERATIVE NOTES ENCLOSED? YES ☐ NO ☐

9. DOES EMPLOYEE REQUIRE FURTHER TREATMENT? YES ☐ NO ☐

10. WAS EMPLOYEE HOSPITALIZED? YES ☐ NO ☐

11. HOSPITAL NAME:
ADDRESS:
CITY:

12. DESCRIBE ANY PRE-EXISTING CONDITION:

13. STATE IN EMPLOYEE'S OWN WORDS HOW ACCIDENT OCCURED:

14. ARE PHYSICIAL RESTORATION SERVICES INDICATED? YES ☐ NO ☐

15. ARE VOCATIONAL RESTORATION SERVICES INDICATED? YES ☐ NO ☐

16. IS THE EMPLOYEE'S PRESENT DISABILITY A RESULT OF INJURY DESCRIBED ABOVE? YES ☐ NO ☐

17. WILL THE INJURY RESULT IN:
☐ A. PERMANENT DEFECT? IF SO WHAT?
☐ B. SERIOUS FACIAL, HEAD, OR BODY DISFIGUREMENT?

18. EMPLOYEE CAN RESUME REGULAR WORK ON
OR LIGHT WORK

NOTE: PLEASE DO NOT USE THIS FORM FOR RATINGS USE THE 25R OR A LETTER

FED. TAX ID# _____

DATED

ATTENDING PHYSICIAN _____

MAKE CHECKS PAYABLE TO:

MAIL 2 COPIES OF THIS FORM AND MEDICAL REPORTS TO CARRIER - ORIGINAL COPY MUST BE MAILED TO THE COMMISSION BY EMPLOYER OR INSURANCE CARRIER.